NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

NOV 2 4 2015

Mr. Michael Melendez
Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

RE: SPA #15-0059
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #15-0059 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective January 1, 2016 (Appendix I). This amendment is being submitted based on State regulations. A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with and promote efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by §1902(a)(30) of the Social Security Act and 42 CFR §447.204.

Copies of pertinent sections of proposed State statute are enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on October 14, 2015, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact John E. Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 474-6350.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: **15-0059**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **January 1, 2016**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **§ 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 01/01/16-09/30/16 $ 75.00** **b. FFY 10/01/16-09/30/17 $ 100.00**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: 2(o)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B: 2(o)**

10. SUBJECT OF AMENDMENT:
2016 DTC APG Capital Cost Update
(FMAP = 50%)

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Division of Finance and Rate Setting** **99 Washington Ave – One Commerce Plaza** **Suite 1460** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: NOV 2 4 2015	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

Appendix I
2016 Title XIX State Plan
First Quarter Amendment
Amended SPA Pages

New York
2(o)

APG Rate Computation – Freestanding Clinics

The following is a description of the methodology to be utilized in calculating rates of payment for freestanding clinics and ambulatory surgery center services under the Ambulatory Patient Group classification and reimbursement system.

I. Claims containing ICD-9 diagnostic and CPT-4 procedure codes are submitted to the Department on appropriate forms or in the accepted electronic format.
II. Claims are reviewed electronically to assign each valid procedure code to the appropriate APG using the APG software logic. Invalid codes will be assigned to an error APG and not given further consideration in the payment process.
III. Each valid APG on the claim is assigned a relative weight. At this time the software logic also determines an allowed weight based upon whether each APG on the claim is to be paid in full, packaged, consolidated, or discounted.

IV. The allowed weights for each valid APG on the claim are then summed to arrive at the final weight for this claim. This final weight is multiplied by an operating base rate that is specific to the peer group to which the claim has been assigned resulting in the APG operating cost reimbursement amount for this claim. For freestanding clinic services, capital will continue to be paid as an add-on using the existing, previously approved methodology. Beginning January 1, 2016, the capital add-on for Article 28 freestanding clinic services shall be the result of dividing the total allowable capital costs associated with Article 28 services by the Article 28 total number of visit or procedures. The capital cost component for ambulatory surgery services shall be the result of dividing the total amount of capital cost reimbursement paid to such facilities pursuant to the current Products of Ambulatory Surgery (PAS) system for the 2007 calendar year for the Upstate Region and for the Downstate Region and then dividing each such regional total amount by the total number of claims paid through the PAS system within each such region for the 2007 calendar year.

V. A separate base rate calculation shall be calculated for each peer group established by the Department. All Medicaid reimbursement paid to facilities for services moving to the APG reimbursement system (e.g., freestanding clinic and ambulatory surgery center services) during the 2007 calendar year and associated ancillary payments will be added to an investment of $9.375 million for dates of service from September 1, 2009 through November 30, 2009, and $50 million for each annualized period thereafter to form the numerator. A link to the base rates can be found in the APG Reimbursement Methodology – Freestanding Clinics section. The peer group specific case mix index multiplied by the coding improvement factor and the 2007 base year visits will form the denominator resulting in a base rate for that peer group.

Appendix II
2016 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #15-0059

This State Plan Amendment proposes to revise provisions of the capital component reimbursement methodology of Article 28 Freestanding clinics on or after January 1, 2016.

Appendix III
2016 Title XIX State Plan
First Quarter Amendment
Authorizing Provisions

Effective Date: 12/03/2008
Title: Section 86-8.4 - Capital reimbursement

Section 86-8.4 Capital cost reimbursement

A capital cost component shall be added to Medicaid payments made pursuant to this Subpart and computed in accordance with the following:

(a) The computation of the capital cost component for payments for general hospital outpatient and emergency services shall remain subject to otherwise applicable statutory provisions as set forth in subparagraphs (i) and (ii) of paragraph (g) of subdivision 2 of section 2807 of the public health law.

(b) The computation of the capital cost component for payments for diagnostic and treatment center services shall remain subject to otherwise applicable statutory provisions as set forth in paragraph (b) of subdivision 2 of section 2807 of the public health law.

(1) Beginning January 1, 2016, the computation of the capital cost component for payments shall be the result of dividing the total allowable capital costs associated with Article 28 services by the Article 28 total number of visit or procedures.

(c) The computation of the capital cost component for payments for ambulatory surgery services provided by hospital-based and free-standing ambulatory surgery centers shall be the result of dividing the total amount of capital cost reimbursement paid to such facilities pursuant to Section 86-4.40 of this Title for the 2005 calendar year for the Upstate Region and for the Downstate Region and then dividing each such regional total amount by the total number of claims paid pursuant to such Section 86-4.40 within each such region for the 2005 calendar year.

Volume: A-2

Appendix IV
2016 Title XIX State Plan
First Quarter Amendment
Public Notice

groundwater withdrawal of up to 0.046 mgd (30-day average) from Well 7.

16. Project Sponsor and Facility: Furman Foods, Inc., Point Township, Northumberland County, Pa. Application for renewal of groundwater withdrawal of up to 0.320 mgd (30-day average) from Well 1 (Docket No. 19850901).

17. Project Sponsor and Facility: Furman Foods, Inc., Point Township, Northumberland County, Pa. Application for renewal of groundwater withdrawal of up to 0.190 mgd (30-day average) from Well 4 (Docket No. 19850901).

18. Project Sponsor and Facility: Furman Foods, Inc., Point Township, Northumberland County, Pa. Application for renewal of groundwater withdrawal of up to 0.090 mgd (30-day average) from Well 7 (Docket No. 19850901).

19. Project Sponsor and Facility: Montgomery Water and Sewer Authority, Clinton Township, Lycoming County, Pa. Application for groundwater withdrawal of up to 0.360 mgd (30-day average) from Well 4.

20. Project Sponsor and Facility: Mount Joy Borough Authority, Mount Joy Borough, Lancaster County, Pa. Modification to increase combined withdrawal limit by an additional 0.199 mgd (30-day average), for a total combined withdrawal limit of 1.800 mgd (30-day average) from Wells 1 and 2 (Docket No. 20110617).

21. Project Sponsor: Pennsylvania Department of Environmental Protection, Bureau of Conservation and Restoration. Project Facility: Cresson Mine Drainage Treatment Plant, Cresson Borough, Cambria County, Pa. Application for groundwater withdrawal from Argyle Stone Bridge Well of up to 6.300 mgd (30-day average) from four sources.

22. Project Sponsor: Pennsylvania Department of Environmental Protection, Bureau of Conservation and Restoration. Project Facility: Cresson Mine Drainage Treatment Plant, Cresson Township, Cambria County, Pa. Application for groundwater withdrawal from Cresson No. 9 Well of up to 6.300 mgd (30-day average) from four sources.

23. Project Sponsor: Pennsylvania Department of Environmental Protection, Bureau of Conservation and Restoration. Project Facility: Cresson Mine Drainage Treatment Plant, Gallitzin Township, Cambria County, Pa. Application for groundwater withdrawal from Gallitzin Shaft Well 2A (Gallitzin Shaft #2) of up to 6.300 mgd (30-day average) from four sources.

24. Project Sponsor: Pennsylvania Department of Environmental Protection, Bureau of Conservation and Restoration. Project Facility: Cresson Mine Drainage Treatment Plant, Gallitzin Township, Cambria County, Pa. Application for groundwater withdrawal from Gallitzin Shaft Well 2B (Gallitzin Shaft #1) of up to 6.300 mgd (30-day average) from four sources.

25. Project Sponsor and Facility: Sugar Hollow Water Services, LLC (Susquehanna River), Eaton Township, Wyoming County, Pa. Application for renewal of surface water withdrawal of up to 1.500 mgd (peak day) (Docket No. 20111214).

26. Project Sponsor and Facility: SWN Production Company, LLC (Susquehanna River), Great Bend Township, Susquehanna County, Pa. Application for renewal of surface water withdrawal of up to 2.000 mgd (peak day) (Docket No. 20111217).

27. Project Sponsor and Facility: SWN Production Company, LLC (Susquehanna River), Great Bend Township, Susquehanna County, Pa. Modification to increase surface water withdrawal by an additional 1.750 mgd (peak day), for a total of up to 2.500 mgd (peak day) (Docket No. 20140302).

28. Project Sponsor and Facility: SWN Production Company, LLC (Tioga River), Hamilton Township, Tioga County, Pa. Application for surface water withdrawal of up to 2.000 mgd (peak day).

29. Project Sponsor and Facility: Village of Sidney, Delaware County, N.Y. Modification to extend the approval term of the groundwater withdrawal approval (Docket No. 19860201) to provide time for development of a replacement source for existing Well 2 88.

Project Scheduled for Action Involving a Diversion:

1. Project Sponsor: Seneca Resources Corporation. Project Facility: Impoundment 1, receiving groundwater from Seneca Resources Corporation Wells 5H and 6H and Clermont Wells 1, 3, and 4, Norwich and Sergeant Townships, McKean County, Pa. Modification to add two additional sources (Clermont Well 2 and Clermont North Well 2) and increase the into-basin diversion from the Ohio River Basin by an additional 0.504 mgd (peak day), for a total of up to 1.977 mgd (peak day) (Docket No. 20141216).

Opportunity to Appear and Comment:

Interested parties may appear at the hearing to offer comments to the Commission on any project listed above. The presiding officer reserves the right to limit oral statements in the interest of time and to otherwise control the course of the hearing. Rules of conduct will be posted on the Commission's website, www.srbc.net, prior to the hearing for review. The presiding officer reserves the right to modify or supplement such rules at the hearing. Written comments on any project listed above may also be mailed to Mr. Jason Oyler, General Counsel, Susquehanna River Basin Commission, 4423 North Front Street, Harrisburg, Pa. 17110-1788, or submitted electronically through www.srbc.net/pubinfo/publicparticipation.htm. Comments mailed or electronically submitted must be received by the Commission on or before November 9, 2015, to be considered.

AUTHORITY: Pub. L. 91-575, 84 Stat. 1509 et seq., 18 CFR Parts 806, 807, and 808.

Dated: September 24, 2015.

Stephanie L. Richardson

Secretary to the Commission.

PUBLIC NOTICE

Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to revise provisions of the capital component reimbursement methodology of Article 28 freestanding clinics on or after January 1, 2016. The following changes are proposed:

Effective January 1, 2016, and every January 1 thereafter, the APG capital rates for the Article 28 freestanding clinic services will be calculated using only Article 28 facility capital costs and statistics reported on the 2 year prior Ambulatory Health Care Facility (AHCF) cost report.

The estimated annual change to gross Medicaid expenditures as a result of the proposed amendment is approximately $200,000.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave. – One Commerce Plaza, Suite 1460, Albany, NY 12210, spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Uniform Code Regional Boards of Review

Pursuant to 19 NYCRR 1205, the petitions below have been received by the Department of State for action by the Uniform Code Regional Boards of Review. Unless otherwise indicated, they involve requests for relief from provisions of the New York State Uniform Fire Prevention and Building Code. Persons wishing to review any petitions, provide comments, or receive actual notices of any subsequent proceeding may contact Brian Tollsen, Building Standards And Codes, Department of State, One Commerce Plaza, 99 Washington Ave., Albany, NY 12231, (518) 474-4073 to make appropriate arrangements.

2014-0410 Matter of Narain Singh, 12519 133re Ave, South Ozone Park, NY 11420 for a variance related to the Residential Building Code requirements for elevated residence, at 2509 NYS Route 26 South, Town of Vestal, and Broome County, in accordance with the New York State Uniform Fire Prevention and Building Code.

2015-0521 Matter of Starpoint Central School District, 4363 Mapleton Road, Lockport, NY, 14094 in Niagara County, State of New York. The petitioner requests a variance concerning the relief from fire walls openings as required by Part 705.8 of Title 19-Part 1221 of the Building Code.

2015-0530 Matter of Elizabeth Crane, 21 West 38th Street, New York, NY 10018 for a variance concerning building code regulations limiting fuel oil storage volume within a building.

Involved is an existing multiple residential building, located at 246-248 Centre Avenue, City of New Rochelle, County of Westchester, State of New York.

2015-0539 Matter of Joseph Pecoraro for 12 Manor House Drive, Apt G26, Dobbs Ferry, NY 10522 for a variance concerning building code requirements including existing and handicapped accessibility.

Involved is an existing multiple residence building, located at 12 Manor House Drive, Village of Dobbs Ferry, County of Westchester. State of New York.

Appendix V
2016 Title XIX State Plan
First Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #15-0059

CMS Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. **Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).**

   Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular A-87 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**
   - **(i) a complete list of the names of entities transferring or certifying funds;**
   - **(ii) the operational nature of the entity (state, county, city, other);**
   - **(iii) the total amounts transferred or certified by each entity;**
   - **(iv) clarify whether the certifying or transferring entity has general taxing authority: and,**
   - **(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).**

   Response: Payments made to service providers under the provisions of this SPA are funded through a general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health. The source of the appropriation is the Local Assistance Account under the General Fund/Aid to Localities.

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

   Response: The payments authorized for this provision are not supplemental or enhanced payments.

4. **For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated,**

non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

Response: The State and CMS are having ongoing discussions to resolve remaining issues with prior year's demonstrations, which the 2016 is contingent upon.

5. **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

   Response: The rate methodology included in the State Plan for freestanding diagnostic and treatment and ambulatory surgery center services is based upon the Ambulatory Patient Group (APG) system with the exception of Federally Qualified Health Centers who have the option to opt into the APG system or remain on the Prospective Payment Methodology (PPS) as approved by CMS in SPA 01-03. We are unaware of any requirement under current federal law or regulation that limits individual providers' payments to their actual costs.

ACA Assurances:

1. **Maintenance of Effort (MOE). Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.**

   MOE Period.
   - **Begins on: March 10, 2010, and**
   - **Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.**

   Response: This SPA complies with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

2. **Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.**

Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

Response: This SPA would [ ] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2014.

3. **Please indicate whether the State is currently in conformance with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.**

   Response: This State does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

a) **Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**
b) **Please include information about the frequency inclusiveness and process for seeking such advice.**
c) **Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 11-06, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.